Quick Renewal Questions - Residential Care Facility for the Elderly

Insured Name: ______________________________ Facility #: ______________________________

Location address: ______________________________ Renewal Date: ______________________________

Resident Profile (complete for each resident *no names*)				
Resident	**Age**	**Private Pay or Medicaid?**	**Description of ability to ambulate:** **Ambulatory or Non-Am or Semi-Am** *(Semi-Am includes walker or wheelchair & can transfer themselves or bear weight)* **i.e."Semi-Am -Wheelchair & can transfer"**	**Primary Diagnosis – i.e. age related infirmity, developmental disability, dementia, mental health – if mental health, describe diagnosis.**
#1				
#2				
#3				
#4				
#5				
#6				

Number of Residents (maximum capacity/licensed): ______________________________

Number of Residents (currently in facility): ______________________________

Number of Residents: (non-am vs am): ______________________________

Do you accept Alzheimer's Residents? ______________________________
If so, how many are currently in the facility? ______________________________

Do you accept Mild to Moderate Dementia Residents? ______________________________
If so, how many are currently in the facility? ______________________________

What is the highest level of care you will accept? (Bed-Ridden, Hospice, Alzheimer's, Dementia?)

____

Is there a 24 hour wake staff? ______________________________

Do you have live-in caregivers? ______________________________

Staffing Ratio:
How many direct care staff (including owners and administrators) are working at a time on each shift.
Please include start and stop times for each shift. (e.g. (7am- 3pm) ___2 caregivers___)

First Shift: (-   ) ______________________________
Second Shift: (-   ) ______________________________
Third Shift (if appl): (-   ) ______________________________

Staff Roster:
Please provide the Names, Titles and years experience of each staff member including owners and administrators:
(e.g. John Smith, Caregiver (15 years experience))
1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

____
Signature   Date

32107 Lindero Canyon Road, Suite 228 Westlake Village, CA 91361
(805) 413-5668 Phone (805) 367-4521 Fax
License No. 0I56077 blake@insuremyrcfe.com www.insuremyrcfe.com

DESIRED EFFECTIVE DATE OF COVERAGE:___________

1. **GENERAL INFORMATION** Facility #:______________________________

Name of Applicant: ______________________________

Address:______________________________

City/State/Zip:______________________________

Contact for Inspection:______________________E-Mail:__________________Web Address:______________________

2. **APPLICANT IS:** Non Profit:☐ For Profit:☐ Other:☐ (Describe:)______________________________
Annual Budget______________________Years Operational:_____________
Are you licensed by state or local authorities: ☐Yes ☐No If yes, name the authority and provide copies of licenses:
____
____

3. **RECORD OF EXISTING INSURANCE: MUST BE COMPLETED IN FULL**

COVERAGE	COMPANY	LIMITS	PREMIUM	EFF. DATE	RETRO DATE
PROFESSIONAL LIABILITY					
GENERAL LIABILITY					
EXCESS AND/OR UMBRELLA					

A. If no insurance exists, is this a new venture? ☐ Yes ☐No
If no, please explain: ______________________________
B. Is expiring professional liability coverage on a **claims made** policy? ☐Yes ☐No Retroactive Date: _______________
If yes, do you desire prior acts coverage? ☐Yes ☐No
C. Does this policy provide Physical/Sexual Abuse Coverage? ☐Yes ☐No
If yes, is this a sublimit? ☐Yes ☐No Limit: ______________________
D. Is coverage claims made? ☐Yes ☐No
Retro Date:____________ What are the "sub-limits": _______________

E. CLAIMS HISTORY

Has the applicant had ANY Professional Liability or General Liability claims and/or incidents (including Physical/Sexual Abuse) that may give rise to a claim in the past 5 years? ☐Yes ☐No

IF YES, PLEASE DESCRIBE IN DETAIL-DATE CLAIM REPORTED, DATE OF LOSS, ALLEGATIONS, AMOUNT RESERVED / PAID, CURRENT STATUS (OPEN OR CLOSED). USE SEPARATE SHEET IF NECESSARY
____
____

4. PHYSICAL AND SEXUAL ABUSE

A. Does your employment application include questions about whether the individual has ever been convicted for any crime, including sex-abuse related offense? ☐ Yes ☐ No
B. Does your state permit you to do criminal background investigations? ☐ Yes ☐ No
If yes, do you routinely request and receive such background investigations? ☐ Yes ☐ No
C. Do you verify employment related references? ☐ Yes ☐ No
If yes: by telephone?____ in person?____
D. Does your organization conduct a personal interview? ☐ Yes ☐ No
E. Do you have a plan that monitors staff in day-to-day relationships with clients? ☐ Yes ☐ No
F. Have you ever had an incident which resulted in an allegation of physical/sexual abuse? ☐ Yes ☐ No
If yes, in a separate attachment please describe in detail each incident.

5. RISK MANAGEMENT

A. Does management have a written "safety program"? ☐ Yes ☐ No

If yes, does it contain the following elements:

a. loss control ☐ Yes ☐ No
b. identification and investigation of potential claims ☐ Yes ☐ No
c. safety/security controls and procedures ☐ Yes ☐ No
d. written emergency plan including evacuation and transportation ☐ Yes ☐ No
e. are staff members made aware of procedures in the event of an emergency? ☐ Yes ☐ No

B. Do you have a fall prevention program? ☐ Yes ☐ No

Does it include the following:

a. an assessment tool for determining residents who are at risk of falling ☐ Yes ☐ No
b. are falls monitored and tracked so as to assess patterns or trends ☐ Yes ☐ No
c. are handrails provided in bathrooms and halls ☐ Yes ☐ No
d. are call buttons operational in all rooms ☐ Yes ☐ No
e. is there a 24 hour "awake" staff on duty ☐ Yes ☐ No

C. Are all prospective clients/residents subject to preadmission screening ☐ Yes ☐ No

D. If you have Alzheimer's residents please answer the following

a. there is a specialized unit to handle just these residents ☐ Yes ☐ No
b. elopement risk assessment is performed on the resident at the time of admission ☐ Yes ☐ No
c. how often are assessments performed ? quarterly ______ annually ______
d. staff reports wandering behavior to facility administrator or social worker ☐ Yes ☐ No
e. how many elopements have occurred in the past 12 months? ___________

THE NAMED INSURED **AND** FACILITY DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, IT WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT, INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

*Notice applicable in most states:
Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance, or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Application must be signed and dated by **applicant and agent**

Date:____________________________________ Signature:____________________________________
(Applicant/Owner/President)

Title:____________________________________

Application must be signed and dated by Agent for the Applicant:

Date: ___________ Name of Agency: ______________________ Name of Agent: ______________________

Location Information Supplement

Please fill in a separate form for each location to be insured

1. **LOCATION NO.** ___________ **Number of Beds This Location**_____________
   - **A.** Name of Facility (if different from named insured) ____
   - **B.** Address:____

Information that concerns this facility: Please complete.

A. YEAR OF CONSTRUCTION	
B. NUMBER OF STORIES	
C. OCCUPIED BY APPLICANT (Stories)	
D. Was the building occupied by the insured at this location built specifically for LTC occupancy? If "no" has it been modified so that it has necessary safety and security devises as required by Federal, State and local authorities?	☐Yes ☐No ☐Yes ☐No
E. PROTECTIVE DEVICES Automatic Sprinklers Heat Sensors Smoke Detectors	 ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No
F. FIRE ESCAPES	#______
G. Swimming Pool	☐Yes ☐No
H. Year of Updates in Construction *Plumbing *Wiring	Year: ______ ☐Yes ☐No ☐Yes ☐No
I. Owned or Leased	
ATTACH Property Acord forms 125 & 140 (IMPORTANT)	

2. **DESCRIPTION OF SERVICES PROVIDED**

Basic Care/ Independent Living: Basic Care is defined as non-medical, aged including developmentally disabled and trained retarded persons. Residents are 100% ambulatory. The goal of the facility is to provide a protective environment where the client is responsible for his/her own care. **Number of Licensed Beds_______ Number Occupied __________**

Intermediate Care/Assisted Living: Intermediate care is defined as limited medical care provided. All non-ambulatory residents are on the ground floor if the facility is more than one story. Usually 10% or less of the population will include residents with dementia. The care provided includes help with daily living and personal care issues such as walking, and meals. Dispensing of medication prescribed by the clients' personal physician is acceptable.

Number of Licensed Beds_______ Number Occupied __________

Alzheimer's Care: Includes residents who are senile – aged; up to and including those with full blown Alzheimer's disease.

Number of Licensed Beds_______ Number Occupied __________

Skilled Care: Skilled Care provides more intensive care that goes beyond intermediate or assisted living care and usually provides complex nursing such as IV's, tube feeding and critical medication dispensing.

Number of Licensed Beds ______ Number Occupied__________

3. **AGE CENSUS**

Current Age Groups				Current Patient Census – residents receiving services related to:		
Age Group	**# of Beds that are Designated/Licensed**	**# of occupied beds**		**Service**	**# Ambulatory**	**# Non-Ambulatory**
Less than 21				Alzheimers		
21-49				Aged but mentally functional		
50-55				Aged but physically functional		
Over 55				Aged but mentally and physically functional		
				Other		

NUMBER OF RESIDENTS USING:

A. Wheelchairs________ Canes_________ Walkers_________ Scooters________

B. Total number of residents at this location? _____________________

4. CURRENT ADMINISTRATION   PLEASE COMPLETE THE CHART BELOW

Position	Name	How many yrs. in this position as this facility?	How many yrs. experience in this position?	How many hours are worked per week?	Employee or independent contractor?
Administrator					
Director of Nurses (DON)					
Medical Director					
Risk Manager					

5. With respects to the Administrator:

1. Who is in charge when the administrator is absent (provide name and title)? _________________________________
2. How many administrators has the facility employed in the past 10 years? ____________________________________

6. STAFFING RATIO

Actual number of direct care staff working at a time on each shift.

1. First Shift __________________
2. Second Shift _______________
3. Third Shift _________________